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Nos. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeals From the Supreme Judical Court For The Commonwealth Of Massachusetts

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BRIEF OF AMICI CURIAE AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS AND SKIP OF NEW YORK, INC. IN SUPPORT OF APPELLEE

BRUCE H. SCHNEIDER
(Counsel of Record)
MADELAINE R. BERG
STROOCK & STROOCK & LAVAN
Seven Hanover Square
New York, New York 10004
(212) 806-5400

HERBERT SEMMEL
NEW YORK LAWYERS FOR THE PUBLIC INTEREST, INC.
36 West 44th Street
New York, New York 10036
(212) 575-5138

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INTERESTS OF AMICI CURIAE

American Public Health Association

The American Public Health Association ("APHA"), founded in 1872, is the oldest and largest professional public health society in the world, with a combined national and affiliate membership of over 50,000 health professionals. APHA members include physicians, dentists, nurses, social workers, health planners and administrators, officials and employees of federal, state and local public health agencies, and other health professionals.

APHA strives to promote the health of the American people by promoting the availability of health services, encouraging a safe and healthful environment, launching public health education programs, and publishing numerous materials reflecting developments in public health.

APHA has advocated comprehensive health services and has urged public recognition that mental and physical health are related and that the physical health of the population cannot be maintained without the availability of mental health services. To this end, APHA has urged governmental action to insure the availability of outpatient mental health services.

American Academy of Pediatrics

The American Academy of Pediatrics is a not-for-profit Pan-American association of 24,000 board-certified pediatricians possessing at least five years of specialized study or practice in pediatrics. The overall objective of the Academy is to maximize the quality of medical care available to children.

In 1973, the Academy, with the assistance of the Health Insurance Association of America, developed the Model Newborn Children Bill. The Model Bill requires any

health insurance policy that covers children of an insured to cover newborns from birth. All fifty states have now adopted laws embodying the substance of the Model Bill.

SKIP of New York, Inc.

SKIP of New York, Inc., a New York non-profit corporation, assists families of chronically ill and disabled children and ventilator-dependent adults in obtaining necessary health and social services. SKIP assists families in arranging for children to be cared for in their homes rather than hospitals. State laws which mandate home health care benefits in health insurance policies are vital to SKIP's mission of facilitating the integration of disabled children into family life. In addition, SKIP is concerned with maintaining state laws and regulations requiring health insurance coverage of dependent children from the date of birth and prohibiting the

exclusion from coverage of congenital conditions and illnesses.[1]

SUMMARY OF ARGUMENT

The states, exercising traditional powers to regulate the substantive content of insurance policies, have mandated the inclusion of minimum levels of benefits in all health insurance policies issued in their jurisdictions. These laws have assured millions of Americans of health insurance coverage for newborn children, out-patient mental health services, drug and alcohol abuse treatment, home health care and the services of numerous health care professionals.

When it enacted ERISA, Congress specifically exempted from federal preemption state laws which regulate insurance.

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[1] The parties have consented to the filing of this brief. Copies of their letters of consent have been filed with the Clerk of the Court, pursuant to Rule 36.2.

In creating this exemption, Congress was certainly mindful of the role that the states had traditionally played to protect insureds by regulating the substantive content of health insurance policies. Subsequent to ERISA's enactment, Congress, the Department of Labor, the Solicitor General and a number of courts have all concurred in the view that it was not Congress' intent to nullify powers exercised by the states to protect insureds from risks of health care expenses which the states, as a matter of public policy, have determined to be intolerable.

That the states are prevented from similarly regulating the benefits offered by self-insured employee benefit plans cannot justify depriving the states of their power to regulate the content of health insurance policies which are properly within their regulatory jurisdiction.

Congress intended to balance the burdens of compliance against the protections to be afforded employees. ERISA recognized that protections afforded employees under state law may outweigh ease of administration and uniformity of benefits in that balance.

That health insurance benefits are a mandatory subject of collective bargaining does not foreclose the states from legislating minimum acceptable levels of benefits in health insurance policies purchased by employee benefit plans. The enactment of state laws regulating hours, wages and working conditions has not been found to unduly restrict the collective bargaining process or otherwise interfere with federal labor policy objectives.

Congress has reserved to the states the regulation of the business of insurance. The level of benefits provided in an insurance policy constitutes an

integral part of the business of insurance which Congress intended to leave for state regulation. Neither ERISA nor federal labor policy indicates an intent to alter the boundary Congress has set for permissible state regulation.

ARGUMENT

I. IN EXEMPTING FROM ERISA'S PREEMPTION STATE LAWS WHICH REGULATE INSURANCE, CONGRESS INTENDED TO PRESERVE FOR EMPLOYEES THE PROTECTIONS WHICH STATE LAWS HAVE TRADITIONALLY AFFORDED THOSE INSURED BY GROUP HEALTH POLICIES.

At issue in these appeals is the continued vitality of protections, mandated by state law, which millions of Americans have come to rely upon as part of their health care insurance. Acceptance of appellants' argument would result in nullifying a power which the states have exercised to guarantee to insureds in their states a minimum acceptable level of health insurance and other insurance benefits, without any substitution of federal regulatory protection.

Each of the fifty states and the District of Columbia has exercised this power in one respect or another to regulate the substantive content of health insurance policies offered to employees in their jurisdictions. By mandatory legislation, the states have sought to close gaps in existing health care coverage and to secure for employees adequate insurance protection, inter alia, for newborns, the handicapped and others who would be overlooked by the unregulated operation of the insurance marketplace. If the states are prohibited from enacting required minimum benefits, a regulatory void would exist in which employees may be exposed to risks of health care expenses that, as a matter of policy, the states have determined to be unacceptable.

Section 514 of ERISA is a complex statement of Congress' intended delineation of the respective authorities of the

federal and state governments to regulate employee benefit plans. Speaking broadly, Congress explicitly stated that ERISA was to preempt any state laws that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). Simultaneously, however, Congress carved out exceptions to the general principle of federal preemption for permissible state regulation. Id. § 1144(b). As to these excepted areas of state interest, the otherwise broad rule of preemption has no application. See Shaw v. Delta Air Lines, Inc., 103 S. Ct. 2890 (1983). These appeals focus upon the "savings" clause, the exception in which Congress declared that ERISA should not "be construed to exempt or relieve any person from any law of any State which regulates insurance". 29 U.S.C. § 1144(b)(2)(A).

A. States Have Traditionally Regulated Insurance Benefits Under Their Police Powers

The regulation of insurance is a necessary and proper exercise of a state's police power. See, e.g., Blue Cross v. Commonwealth, 269 S.E.2d 827, 835-37 (Va. 1980). In appellants' view, the traditional role of the states in insurance regulation has been, and should be, limited to: (i) the supervision of the insurance carriers themselves, including regulations such as minimum capitalization requirements, criteria for the investment of funds and character standards for insurance company management; and (ii) the regulation of business practices in the selling of insurance, including the licensing of agents and brokers, setting standards of conduct for sales and advertising, and rate-making.

In addition to these areas, however, the states have traditionally exercised their police power to regulate the

substantive content of insurance contracts, including the scope of coverage and benefits offered. See generally Insurance Commissioner v. Metropolitan Life Insurance Co., 296 Md. 334 (1983) and cases cited therein; Brummond, Federal Preemption of State Insurance Regulation under ERISA, 62 Iowa L. Rev. 57, 83-84 (1976). This form of regulation is in furtherance of the state's interest in assuring that insureds are treated fairly and equitably by insurance carriers. Regulation of the content of insurance policies "may be regarded as ensuring that the insured gets what he pays for, or - going somewhat further - as requiring the company to give the insured what he must have assumed he was paying for." Kimball, The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law, 45 Minn. L. Rev. 471, 491 (1961).

The states regulate the content of a wide variety of insurance contracts through statutes mandating the minimum acceptable scope of coverage.[2] Provisions of insurance contracts which are so familiar as to appear commonplace, in fact, have their origins in state regulation.[3] In addition, states confer upon regulatory officials broad authority to disapprove policies that are inequitable, misleading or unreasonable in relation to the premium

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[2] See, e.g., N.Y. Ins. Law §§ 3220 (group life), 3221 and 4235 (group accident and health), 3216 (individual accident and sickness), 3420 (liability), and 3404 (fire) (McKinney Supp. 1984).

[3] For example, state statutes mandate the inclusion of clauses in life insurance policies that limit exclusions from coverage for death by suicide to those occurring within two years of the issuance of the policy. See, e.g., Md. Code, Art. 48A; § 410(a)(5) (1979); N.Y. Ins. L. § 3202(b)(1)(B) (McKinney Supp. 1984). State statutes also mandate minimum levels of uninsured motorist coverage in automobile insurance policies. See, e.g., Md. Code, Art. 48A, § 541(c)(2)(1979); N.Y. Ins. L. § 5103 (McKinney Supp. 1984).

charged.[4]

The states utilized this power to govern the content of health insurance policies prior to the enactment of ERISA.[5] Appellants' arguments that state-mandated benefit laws are of recent creation, designed to usurp power in contravention of federal policy, and a departure from the historic and proper regulatory function of the states is contrary to historical fact. Among the earlier forms of mandatory benefit laws adopted by the states were laws requiring that policy coverage of minors continue beyond the maximum age limit

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[4] See, e.g., Ill. Rev. Stat., ch. 73, § 755(2) (1965); N.Y. Ins. L. § 3201 McKinney Supp. 1984).

[5] For example, in 1958, New York mandated that group health insurance policies contain a provision permitting an individual who terminated his employment to convert the policy into an individual policy which must include specified minimum levels of coverage. See N.Y. Ins. L. § 3221 (McKinney Supp. 1984) (recodifying N.Y. Ins. L. § 162(5) (McKinney 1966)).

(usually 19) where those dependents are incapable of self-sustaining employment because of

mental or physical handicap and are chiefly dependent upon the subscriber for support.[6]

Another manner in which the states have exercised this power is to require that group health insurance coverage for infants commence from the moment of birth. The need for such legislation grew out of the fact that a significant number of family health insurance policies excluded newborn infants from coverage for

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[6] See Table II in the Appendix to this brief. The Appendix to the Brief of Amicus Curiae Health Insurance Association of America in Support of Jurisdictional Statements surveys the wide variety of benefits mandated by state laws which include: outpatient mental health services, drug and alcohol abuse treatment, home health care and the services of numerous health care professionals. That survey, however, omits two forms of coverage mandated by state law which are of particular interest to these amici: mandatory coverage of newborns from birth and mandatory coverage of mentally or physically handicapped dependents.

the first fourteen to thirty days of their lives. Schulkind, Morrisey & Morton, Neonatal Health Insurance, 13 Clinical Pediatrics 209 (Mar. 1974) (hereinafter cited as Schulkind); J.A. at 346, 454. Immediate coverage of newborns usually could have been obtained if requested; however, the average insurance buyer was unaware of either the newborn exclusion or of the option to have the newborn included.[7] Schulkind, supra at 209. Since more infants die in the first seven days of life than in the remainder of the first year of life, those insurance policies failed to give protection during the interval of greatest risk. Benfield, The Newborn Health Insurance

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[7] Union members whose insurance policies were the product of collective bargaining were not immune from the surprise of discovering their newborn's medical expenses were not covered. See Benfield, The Newborn Health Insurance Exclusion Clause Eradicated in Ohio, 15 Clinical Pediatrics 19 (Jan. 1976).

Exclusion Clause Eradicated in Ohio, 15 Clinical Pediatrics 19 (Jan. 1976). Faced with a newborn who was premature or sick, parents without insurance coverage for the child were required to take on debts of burdensome magnitude and even become dependent on the state for support. See Schulkind, supra at 210; J.A. at 454.[8] In addition, because coverage did not begin

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[8] The sponsor of the New York legislation mandating coverage of newborns from birth viewed the purpose of this legislation as being to "provide a more comprehensive and fair family heath insurance plan for insured families within the state." 1977 New York State Legislative Annual 214. Mandatory coverage was necessary because:

> [p]resently family plans do not cover new born infants until 10-days from birth. Thus if the child is born with a birth defect or malady the family must bear the medical costs. This situation can severely burden the financial well-being of the family for some time to come and also the physical well-being of the child.

Id.

from the moment of birth, a family might also learn that there would be no coverage for the treatment of a child who was congenitally ill since this was a "pre-existing condition", antedating the policy's coverage.

In November 1973, the American Academy of Pediatrics, with the assistance of the Health Insurance Association of America, developed the Model Newborn Children Bill which required that health insurance coverage be extended to infants from the moment of birth. Since that time, every state has mandated coverage affording protections similar to the Model Bill. See Appendix, Table I.

The protections accorded by state laws mandating the coverage of newborns from birth have grown increasingly important. Advances in neonatal pediatric medicine have made it possible for infants born with life-threatening conditions to

survive. Infants born prematurely, weighing no more than two pounds at birth now have the potential for survival. These ever increasing technological capacities create enormous opportunities, but at enormous costs. An estimated 6% of live-born infants are treated in a neonatal intensive care unit, where the length of stay averages 8-18 days. In 1978, $1.5 billion was spent on neonatal intensive care unit care. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 204 (Mar. 1983). The hospital costs of a newborn with a birth defect run from $800 to $1,000 a day, with doctor bills adding another $200 to $400 daily. A sixty day confinement for a relatively simple to treat but common infant ailment like bacterial pneumonia costs $50,000 to $60,000. A single claim for a premature child with heart and respiratory

problems came to $707,000. N.Y. Times, Dec. 9, 1984, at F11, col. 3.[9] In the absence of state laws mandating coverage during this high risk period of life, insurers may revert to the prior practice of excluding newborns from health insurance coverage.

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[9] Although the cost of neonatal care is enormous, a relatively small number of families are involved. Mutual of Omaha estimates that only one in 10,000 claims exceeds $50,000. N.Y. Times, Dec. 9, 1984, at F11, col. 3. These costs are inconsequential in the broad health care delivery system in which more than 400 billion dollars will be spent in 1985. The coverage of neonatal medical treatment fits squarely within the objective of insurance of spreading and socializing a risk. See Kimball, supra, 45 Minn. L. Rev. at 512-514.

B. Since Federal Law Does Not Address Minimum Levels of Health Insurance Benefits, State Laws Are Not to be Preempted Since That Woudl Create an Undesirable Regulatory Void.

Congress was fully aware of how instrumental insurance was to the operation of employee benefit plans. This understanding was reflected in, inter alia, the statutory definition of an employee benefit plan as one providing benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1).

"When ERISA was enacted, . . . Congress certainly knew that much of the body of state law regulating insurance concerned required coverages in various categories of insurance." Insurance Commissioner v. Metropolitan Life Insurance Co., 296 Md. 334, 340 (1983). Yet, Congress laid down a broad exemption from the

general principle of federal preemption for "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A).[10]

Since the regulation of insurance is primarily a state function, the court below made a reasonable and correct analysis of the inter-relationship of state and federal law.

> Where . . . the field which Congress is said to have pre-empted has been traditionally occupied by the States, . . . "we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

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[10] Indeed, to say that the savings clause does not apply to state laws regulating insurance policies sold to ERISA plans would render the saving clause meaningless. Obviously, only those policies which are sold to employee benefit plans could, in the first instance, be preempted under § 514(a). There is no need to "save" an insurance regulation which does not "relate" in any way to an employee benefit plan.

Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)). Since Congress expressly exempted state laws regulating insurance from the preemption it otherwise mandated, it was appropriate for the court below to apply general principles flowing from the Supremacy Clause and infer federal preemption only to the extent that there was a clear conflict between state and federal law. See, e.g., Silkwood v. Kerr-McGee Corp., 104 S.Ct. 615 (1984); DeCanas v. Bica, 424 U.S. 351 (1976); Florida Lime and Avocado Growers, Inc. v. Paul, 373 U.S. 132 (1963).[11] Since ERISA does not purport to

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[11] The Court below did not, as appellants contend, resurrect the "conflict-based" analysis rejected by this Court in Shaw, 103 S. Ct. at 2900-01. The portion of the Shaw opinion referred to focused on the reading to be given to Congress' express declaration of preemption in § 514(a). Since Congress specifically exempted insur-

Footnote continued

address required levels of health insurance benefits, Shaw v. Delta Air Lines, Inc. 103 S. Ct 2890, 2897 (1983), it is apparent that there is no conflict between state and federal law. To say that the states may not regulate the content of health insurance policies even where federal law does not address minimum benefits is to create an unacceptable regulatory void, which Congress cannot be assumed to have intentionally created. See Okin, Federal Preemption of State Law Under ERISA: An Examination of the Effects of the Federal Mandate in the Light of Authoritative Precedent Under the Supremacy Clause, the McCarran-Ferguson Act and the Legislative History, 24 Ass'n of

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ance regulation from the rule of preemption that it expressly created in § 514(a), the court below did not commit error in employing the analysis it did to determine whether preemption should be implied in § 514(b); that is, whether the state enactment conflicts with federal law.

Life Ins. Counsel Proceedings 115, 151 (1976)[12]

C. The Executive, Legislative and Judicial Branches of Government Have Concurred That ERISA's Enactment Did Not Deprive the States of Their Authority to Regulate the Content of Health Insurance Policies.

The First Circuit has authoritatively addressed the insurance exception in section 514(b) and has held state-mandated benefit laws to be a lawful exercise of state regulation within ERISA's insurance "savings" clause. See Wadsworth v.Whaland, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).[13]

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[12] The author of this article, Franklin J. Okin, was, at the time of its writing, Associate General Counsel of The Travelers Insurance Company. According to Mr. Okin, "It would be a subversion of the purposes of ERISA and national policy to say that the ERISA preemption provision was designed to create a regulatory void." Okin, supra at 151.

[13] Other courts have similarly taken the position that state statutes specifying mandatory minimum benefits in insurance policies are laws regulating insurance

Footnote continued

In Wadsworth, administrators of various health and welfare funds contended that ERISA preempted a New Hampshire law requiring issuers of group health insurance policies to include coverage for the treatment of mental illness and emotional disorders and that the state law was invalid insofar as it required employee benefit plans to purchase insurance policies that included the state-mandated coverage. Id. at 73.

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within the meaning of the "savings" clause of § 514(b)(2)(A) of ERISA. Insurance Commissioner v. Metropolitan Life Insurance Co., 296 Md. 334 (1983); Wayne Chemical, Inc. v. Columbus Agcy. Serv. Corp., 567 F.2d 692, 699, 700 (7th Cir. 1977); New Hampshire-Vt. Health Serv. v. Whaland, 119 N.H. 886 (1979); Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162, 1168-1170 (C.D. Cal. 1980); Cate v. Blue Cross & Blue Shield, 434 F. Supp. 1187 (E.D. Tenn. 1977); Insurers' Action Council, Inc. v. Heaton, 423 F. Supp. 921,926 (D. Minn. 1976).

The First Circuit held that, pursuant to the "savings" clause, the states were not forbidden "from affecting employee benefit plans by regulating group insurance." Id. at 78. The Court declined to interpret ERISA in a manner that "would nullify all state insurance laws concerning group insurance when the group policy is issued to an employee benefit plan" in the absence of a clear Congressional intent to so restrict "the state's primacy in regulating insurance". Id.

At this Court's invitation in its consideration of plaintiffs' petitions for a writ of certiorari in Wadsworth, 434 U.S. 1044 (1978), the Solicitor General expressed the view of the United States that a state statute mandating inclusion of mental health coverage in group health insurance policies was not intended to be preempted by ERISA. With respect to section 514(b)(2)(A), the "savings" clause

at issue here, the Solicitor General stated:

> This savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans, since no other state law regulating insurance would be subject to preemption-under the Act even in the absence of the savings provision. [The New Hampshire law mandating mental health coverage] obviously "regulates insurance," and thus the court correctly found that Congress intended that law and others like it to remain effective regardless of ERISA's otherwise broad preemption of state laws relating to plans.

Dkt. Nos. 77-765 and 77-772, Memorandum for the United States as Amicus Curiae (hereinafter cited as "Solicitor General's Wadsworth Brief") at 7.[14]

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[14] The Solicitor General made it plain that he was also expressing the view of the Department of Labor, the executive department charged with administering ERISA. "As this Court has often recognized, the con-

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In 1979, following the decision in Wadsworth, Senators Williams and Javits, the sponsors of the original ERISA bill, proposed S.209, the ERISA Improvements Act of 1979. While the proposed Act primarily concentrated on remedying regulatory deficiencies in pension plan administration, section 155 of the bill would have preempted state-mandated benefit laws by adding to section 514(b)(2)(B) the following:

> A State insurance law which provides that a specific benefit or benefits must be provided or made available by a contract or policy of insurance issued to an employee benefit plan is a law which relates to an employee benefit plan within the meaning of subsection (a) and is not a law which regulates insurance within the meaning of subparagraph (A).

S.209, 96th Cong., 1st Sess. § 155, 125 Cong. Rec. 937 (1979). According to Senator Javits, the proposed amendment to section 514 was intended to legislatively overrule the decision in Wadsworth v. Whaland. See 125 Cong. Rec. 947 (1979). The bill, however, was never enacted.[15]

Congress' failure to enact the amendment evidences its belief that the holding in Wadsworth was not contrary to

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struction of a statute by those charged with its administration is entitled to substantial deference." United States v. Rutherford, 442 U.S. 544, 553 (1979). See also Board of Governors v. First Lincolnwood Corp., 439 U.S. 234, 248 (1978); Bayside Enterprises, Inc. v. NLRB, 429 U.S. 298, 304 (1977); Udall v. Tallman, 380 U.S. 1, 16 (1965).

[15] Interestingly, though, in 1979, Congress was called upon to consider state-mandated benefit laws in a different context. In that year, the Council of the District of Columbia passed a law mandating newborn coverage in group health insurance policies. The local law was transmitted to Congress for its review, pursuant to the District of Columbia Self-Government and Governmental Reorganization Act, Pub. L. No. 93-198, 87 Stat. 774 (1973). Congress did not disapprove and the enactment took effect. D.C. Code § 35-1101 (Supp. 1983).

the original intent of Congress in enacting ERISA with its exception to preemption for state insurance laws, and that therefore, no remedial legislation was necessary. See Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723, 733 (1975); Blau v. Lehman, 368 U.S. 403, 412-13 (1962). In failing to enact the amendment under the circumstances "Congress [was] not merely expressing an opinion . . . but [was] acting on what it [understood] its own prior acts to mean." Bell v. New Jersey and Pennsylvania, 103 S.Ct 2187, 2194 n. 12 (1983) (quoting Mount Sinai Hospital v. Weinberger, 517 F.2d 329, 343 (5th Cir. 1975)).

In light of the clear opportunity that Congress had to amend the preemption-provision -- if it believed Wadsworth was incorrectly decided -- its failure to enact the amendment "strongly militates against a judgment that Congress intended a result that it expressly declined to enact." Gulf

Oil Corp. v. Copp Paving Co., 419 U.S. 186, 200, (1974). Congressional failure to expand federal authority is indicative of its view of the limits to the prior legislation, as well as its reluctance to broaden that legislation. Bowsher v. Merck & Co., 103 S.Ct 1587, 1595 (1983); Bell v. New Jersey and Pennsylvania, 103 S.Ct. at 2194. See also Rostker v. Goldberg, 453 U.S. 57 (1981).

D. The States Are at Liberty to Regulate the the Content of Health Insurance Policies Available to Employee Benefit Plans as Purchasers of Insurance.

As has been shown, state laws mandating the inclusion of particular coverage is a traditional exercise of the state's authority to regulate insurance. There is no evidence that Congress meant to restrict the exercise of that power with respect to group health insurance policies purchased by an employee benefit plan.

> The fact that the purchaser of insurance is an employee benefit plan is immaterial; Congress did not intend to confer any special exemption or privilege on them as insurance buyers. Insurance sales to them must conform to the same rules as those to any other insurance buyer, and if a state determines . . . that all group health insurance sold in the state must provide coverage for mental and emotional disturbance, the plans may purchase no other.

Solicitor General's Wadsworth Brief at 8.

Appellants maintain that, since state laws may not regulate self-insured employee benefit plans, the cost of premiums for state-mandated benefits will induce some plans to self-insure to evade the obligations imposed by state law. To the extent that there has been an increase in the number of self-insured plans, that trend pre-dates the enactment of ERISA, and has developed independently of the demands placed upon employers by mandatory benefits. See Business Insurance, Mar. 10,

1975, at 4, col. 1; R. Goshay, Corporate Self-Insurance and Risk Retention Plans (1964) (cited in M.R. Greene, Risk and Insurance 78 (4th ed. 1977)). The decision of plan trustees to forego the security afforded by spreading the risk through insurance involves complex considerations, the incremental cost of premiums on the additional coverage state law requires being only a relatively small factor.[16]

The states have determined as a matter of public policy that health insurance contracts must contain certain minimum levels of protection for the insured. The creation of comprehensive national health

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[16] Except for the largest, and most stable employee benefit plans, it is unlikely that the additional premium resulting from mandated benefits will, without more, justify self-insurance. "If a firm cannot afford insurance premiums, it is even more unlikely that the firm can afford the loss should it occur, or that the firm can afford to set aside a self-insurance fund." M.R. Greene, supra at 77.

insurance may someday remove the need for these protections. In the interim, however, the states remain free within their regulatory jurisdictions to mandate minimum levels of health insurance benefits. "[R]eform may take one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind." Williamson v. Lee Optical, 348 U.S. 483, 489 (1955). "Legislatures may implement their program step by step . . . adopting regulations that only partially ameliorate a perceived evil and deferring complete elimination of the evil to future regulations." New Orleans v. Dukes, 427 U.S. 297, 303 (1976).

If, because of ERISA's "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), the states are prevented from mandating minimum levels of benefits for self-insured plans, it does not mean that they are, or should be, powerless with respect to insurance

that is within their jurisdictions. That self-insurance may become more attractive to plan administrators because of the cost of state-mandated benefits is no cause to nullify the states' lawful exercise of their police power; to do so would permit the circumvention of law to dictate the principle of law.

E. This Court Has Recognized That Uniformity of Benefits is Not an Absolute Requirement under ERISA.

Appellants, and those amici supporting their position, urge broad preemption to eliminate any differences in benefits and to ease plan administration. Although Congress was concerned with the burdens of compliance with regulation, whether federal or state, it is abundantly clear that Congress did not intend to eviscerate employee protections in the interest of easing the real or claimed burden on plan administrators. The Senate Committee Report reflects the effort to achieve a

balance of the oftentimes competing interests:

> The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations.

S. Rep. No. 127, 93d Cong., 1st Sess. 13 (1973), reprinted in 1974 U.S. Code Cong. & Ad. News 4850.

Shaw v. Delta Air Lines, Inc., 103 S. Ct 2890 (1983), recognized that considerations of uniformity of benefits and ease of administration do not perforce outweigh the protection of state-mandated benefits in that balance. In Shaw, multi-state employers and an insurer challenged, inter alia, the legality of the New York Disability Benefits Law which mandated that

employers provide the same sick-leave benefits to employees unable to work because of pregnancy as for any other disability. This Court found that the Disability Benefits Law was not preempted by ERISA since it came within section 514(b)(3)'s exception for employee benefit plans maintained "solely" for purposes of complying with state disability insurance laws. Id. at 2905. This Court held that

> a state may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply.

Id. at 2906.

Shaw's effect is to subject a multi-state employer to the very sort of non-uniformity of benefits that appellants

claim is anathema to ERISA and requires the preemption of all state-mandated benefit laws. Under Shaw, plan administrators are not to be relieved of their obligation to comply with the laws of the respective states and provide the coverage those states require. Although these laws are in some instances conflicting as to the scope of their coverage, ERISA does not require their preemption. There is no demonstrable reason why differences in state law as to mandatory health insurance coverage should require a different result.[17]

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[17] The difference in coverage which state law may require is illustrated by the rulings of the various states on claims of disability caused by on-the-job stress, without any physical injury. For example, McGarrah v. State Accident Insurance Fund, 296 Or. 145 (1983), held that under the Oregon State Workers' Compensation Law, "stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from the conditions of the worker's employment, providing causation . . . has been proven." Id. at 163. Accord Haydel v. Sears, Roebuck &

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Co., No. 47619 (N.Y. Sup. Ct. App. Div. 3d Dep't Dec. 13, 1984). In contrast, however, Transportation Insurance Co. v. Maksyn, 580 S.W.2d 334 (Tex. 1979), held that the Texas Workers' Compensation Law "drew its line for compensability for occupational diseases by limiting coverage to those cases in which physical activities cause harm or injury and by denying coverage when mental activities cause the harm or injury." Id. at 338. In other states, compensation may depend on whether the on-the-job stress was caused by a one-time incident rather than a prolonged stressful situation. Compare Followill v. Emerson Electric Co., 234 Kan. 791 (1984) (Kansas Workers' Compensation Act does not extend coverage to a disability caused by post-traumatic stress disorder resulting from a single on-the-job accident in which claimant suffers no physical injury) with Todd v. Goostree, 493 S.W.2d 411 (Mo. Ct. App. 1973) (holding that a neurotic disability caused by a one-time emotional shock is a compensable "injury" within the statutory definition of the Missouri Workers' Compensation Law).

II. STATE-MANDATED BENEFIT LAWS, THOUGH AFFECTING A SUBJECT OF MANDATORY COLLECTIVE BARGAINING, ARE NOT PREEMPTED BY FEDERAL LABOR POLICY.

State laws mandating the inclusion of certain benefits in collectively bargained group health insurance contracts are not preempted by federal labor law or policy. Appellants do not find the sweeping preemption they urge in any federal labor statute; nor do they contend that a finding of preemption is necessary to preserve the primacy of the National Labor Relations Board's jurisdiction in the labor-management field. Rather, appellants maintain that since employee benefits are a compulsory subject for collective bargaining, state-mandated benefit laws are an intrusion into an area which federal labor policy requires be unregulated and left entirely to the free play of economic forces.

In Malone v. White Motor Corp., 435 U.S. 497 (1978), this Court confronted

a similar claim that federal labor policy required preemption of the Minnesota Pension Act which established minimum funding and vesting standards for employee pensions. The plaintiff-employers asserted that the state statute was preempted because it imposed on them financial obligations which, by the express terms of a collective bargaining agreement, they were not required to assume. Id. at 502. The Court rejected the notion that merely because they are a subject of compulsory bargaining, pension benefits are therefore placed beyond the lawful reach of state regulation:

> There is little doubt that under the federal statutes governing labor-management relations, an employer must bargain about wages, hours, and working conditions and that pension benefits are proper subjects of compulsory bargaining. But there is nothing in the NLRA . . . which expressly forecloses all state regulatory power with respect to those issues, such as pension plans,

that may be the subject of collective bargaining.

Id. at 504-05. The Court concluded that a congressional intent to preempt state legislation regulating pension plans could not be implied from the federal labor statutes. Id. at 505.[18]

The extension of the doctrine of labor law preemption which appellants seek would prohibit state regulation of any matters affecting, however remotely, subjects of mandatory collective bargaining. This narrow view of state authority was rejected by this Court over forty years ago in Terminal Railroad Association v.

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[18] The Court went on to find a contrary congressional intent --- to permit state regulation --- evident in the enactment of the Federal Welfare and Pension Plans Disclosure Act. 29 U.S.C. §§ 301 et seq. (repealed 1974). Thus, it was the Court's conclusion in Malone that nothing intrinsic to the history of the enactment of federal labor statutes compels preemption of state regulation. But cf. Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 526 and n.23 (1981).

Brotherhood of Railroad Trainmen, 318 U.S. 1 (1943). At issue in that case was a state regulation requiring the company to provide cabooses on its trains. The employer, who was subject to the Railway Labor Act, maintained that the regulation was preempted since the presence of cabooses was a working condition and thus a mandatory subject of collective bargaining. The Court did not find a state's regulation of minimum standards of working conditions to be an interference with federal labor objectives. In upholding the state's regulatory authority, the Court explained:

> The Railway Labor Act, like the National Labor Relations Act, does not undertake governmental regulation of wages, hours or working conditions. Instead it seeks to provide a means by which agreement may be reached with respect to them. The national interest expressed by those acts is not primarily in the working conditions as such. . . .
>
> State laws have long regulated a great variety of

> conditions in transportation and industry, such as sanitary facilities and conditions, safety devices and protections, purity of water supply, fire protection, and innumerable others. . . . It cannot be that the minimum requirments laid down by state authority are all set aside. We hold that the enactment by Congress of the Railway Labor Act was not a preemption of the field of regulating working conditions themselves and did not preclude the State . . . from making the order in question.

Id. at 6-7 (footnote omitted). See also Industrial Welfare Commission v. Superior Court, 27 Cal. 3d 690, appeal dismissed, 449 U.S. 1029 (1980) (federal labor laws do not preempt state regulations establishing minimum wages, maximum hours, or standard conditions of employment); Baltimore & Ohio Railroad v. Department of Labor, 334 A.2d 636 (Pa.), appeal dismissed, 423 U.S. 806 (1975) (no preemption by the Railway Labor Act of state statute requiring railroads to pay employees weekly).

That a matter is a subject for mandatory collective bargaining does not preclude the states from adopting minimum standards below which the terms of a collective bargaining agreement may not go. Although wages, hours and occupational health and safety standards are subjects for mandatory collective bargaining, states have adopted numerous requirements setting minimum standards for each.[19] Rather than

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[19] "States possess broad authority under their police powers to regulate the employment relationship to protect workers within the state. Child labor laws, minimum and other wage laws, laws affecting occupational health and safety, and workmen's compensation laws are only a few examples." DeCanas v. Bica, 424 U.S. 351, 356 (1976). See, e.g., Cal. Lab. Code § 850 (West 1971) (maximum hours and days for persons who sell or compound drugs and medicines); Cal. Lab. Code § 1171 et seq. (West 1971 and Supp. 1984) (authorizing state Industrial Welfare Commission to set minimum standards for wages, hours and working conditions); N.Y. Lab. Law § 190 et seq. (McKinney Supp. 1984-85) (frequency and methods of paying wages); N.Y. Transp. L. § 211 (McKinney Supp. 1984-85) (maximum hours for truck and bus drivers); N.Y. Lab. Law § 240 et seq. (McKinney 1965 and Supp. 1984-85) (workplace safety standards).

leaving these subjects to the free play of economic forces, Congress has enacted legislation setting minimum standards and has, in certain instances, specifically authorized the states to adopt still more protective regulations for the benefit of employees.[20]

Federal labor policy does not require that the states be confined to a more restricted role with respect to health insurance benefits than with respect to other subjects of mandatory bargaining. The contention that if an employer is required to purchase state-mandated insurance coverage there is less money available for wages and other benefits is no less true of state regulation which may compel an employer to

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[20] For example, both the Fair Labor Standards Act of 1938 and the Occupational Safety and Health Act of 1970 authorize the states to adopt more protective regulations for the benefit of employees. 29 U.S.C. § 218 (1975); 29 U.S.C. §§ 651(b)(11), 667 (1975).

hire additional workers to comply with maximum hour restrictions or to install particular safety equipment to satisfy occupational safety requirements. The setting of minimum standards does not dictate the outcome of the bargaining process or interfere with the objectives of the federal labor laws.

III. STATE-MANDATED BENEFIT LAWS ARE PART OF THE REGULATION OF THE "BUSINESS OF INSURANCE" LEFT TO THE STATES BY CONGRESS IN THE MCCARRAN-FERGUSON ACT.

The court below recognized that "[t]he McCarran-Ferguson Act [15 U.S.C. § 1011 et seq.] establishes a congressional policy in favor of State regulation of insurance." Attorney General v. Travelers Insurance Co., 385 Mass. 598, 613-14 (1982). Congressional deference to state regulation of insurance bears upon both appellants' contention of ERISA preemption and their contention of federal labor law preemption.

The McCarran-Ferguson Act provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

15 U.S.C. § 1012(b).

Although the McCarran-Ferguson Act did not define the term "business of insurance," this Court has repeatedly emphasized that the "business of insurance" which is left to state regulation includes state laws regulating the relationship between the company and the insured:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement - these were the core of the "business of insurance:" . . . whatever the exact scope of the statutory term, it is clear where the focus was - it was on the relationship between the insurance company and the policyholder. Statutes

> aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the "business of insurance."

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453, 460 (1969) (emphasis supplied). The Court has identified three criteria relevant to determining whether a particular practice is part of the "business of insurance":

> first, whether the practice has the effect of transferring or spreading a policy-holder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119, 129 (1982). State-mandated benefit laws regulate the "business of insurance" as defined by this Court and constitute the exercise of a power specifically reserved to the states. This is

illustrated by the state-mandated benefit that coverage of newborns begin from the moment of birth.

Mandatory coverage of newborns unquestionably has the effect of spreading the risk of potentially catastrophic expenses of neonatal medical treatment. J.A. 346, 454-55. There can be little doubt that the benefits provided are an integral part of the policy relationship between insurer and insured. Although the scope of benefits is integral to that relationship, it was often only after families incurred ruinous expenses for the care of a congenitally ill child that the insured learned that the coverage relied upon simply was not there because of policy exclusions. J.A. 346, 361, 387, 390, 454-55. Finally, statutes mandating benefits to be included in insurance policies are limited to entities within the insurance industry.[21]

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[21] See generally Schulkind, supra at 209-10.

The McCarran-Ferguson Act's protection of state regulation of the business of insurance is significant in interpreting both the scope of preemption intended by ERISA and the proper role for state-mandated insurance coverage in the collective bargaining process.

Section 514(d) instructed that ERISA was not to "be construed to alter, modify, invalidate, impair, or supersede any laws of the United States," 29 U.S.C. § 1144(d), including, but obviously not limited to, the McCarran-Ferguson Act. Congress surely did not intend to impair the power of the states, reenforced by federal law, to regulate the relationship between the insurer and the insured. There is no basis for suggesting that a narrower meaning is to be attributed to a "law . . . which regulates insurance," 29 U.S.C. § 1144(b)(2)(A) than this Court has given to a "law enacted . . . for the purpose of

regulating the business of insurance," 15 U.S.C. § 1012(b). Were this so, ERISA would certainly "alter, modify, invalidate, impair, or supersede" the McCarran-Ferguson Act.

The McCarran-Ferguson Act's endorsement of state regulation of insurance provides some insight into Congress' intentions. As this Court observed in Malone, the federal labor statutes do not evidence an intent on the part of Congress to preclude state legislation that affects employee benefits. By contrast, in the McCarran-Ferguson Act, Congress manifested an intent to preserve the power of the states to regulate insurance, including the power to regulate the contents of insurance policies. Congress' demonstrated interest in preserving state insurance regulation is "a far more reliable indicium of congressional intent" with respect to the power of the states to mandate insurance coverage,

including coverage purchased to satisfy contractual obligations resulting from collective bargaining. Malone, 435 U.S. at 505.[22]

CONCLUSION

For the foregoing reasons, the American Public Health Association, the American Academy of Pediatrics, and SKIP of New York, Inc. most respectfully urge this Court to affirm the decision of the Supreme Judicial Court of Massachusetts.

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[22] The parallelism between § 10 of the Federal Welfare and Pension Plans Disclosure Act, 29 U.S.C. §§ 301 et seq. (repeated 1974), and the McCarran-Ferguson Act extends further. In both acts, Congress recognized that state regulation was not static and sought to preserve not only existing state law, but "future" enactments as well. Compare Malone, 435 U.S. at 510-11 with Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 431 (1946).

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Respectfully submitted,

BRUCE H. SCHNEIDER
(Counsel of Record)
MADELAINE R. BERG
STROCCK & STROOCK & LAVAN*
Seven Hanover Square
New York, New York 10004
(212) 806-5400

HERBERT SEMMEL
New York Lawyers for the
Public Interest, Inc.
36 West 44th Street
New York, New York 10036
(212) 575-5138

Attorneys for Amici Curiae
American Public Health
Association,
American Academy of
Pediatrics, and SKIP of
New York

* Peter Friedman, a recent law school graduate awaiting admission to the bar of the State of New York, assisted in the preparation of this brief.